

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-016864

Registration District No. 227

Primary Registration District No. 4334

Registrar's No. 18

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY MONROE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY MONROE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JACKSON		c. CITY OR TOWN PARIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1/2 MI. N. OF PARIS, MO		d. STREET ADDRESS (If outside, give location) 311 S. MAIN STREET	
3. NAME OF DECEASED (Type or print) First Middle Last MELVIN RAY EICHOR		4. DATE OF DEATH Month Day Year APRIL 13, 1963	
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/25/1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUCTIONEER		10b. KIND OF BUSINESS OR INDUSTRY AUCTIONEER	
11a. FATHER'S NAME HOWARD J. EICHOR		11b. MOTHER'S MAIDEN NAME MARY RANSDELL	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		13. SOCIAL SECURITY NO. AMY O. EICHOR - PARIS, MO	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Heart Disease DUE TO (c) W.K.		INTERVAL BETWEEN ONSET AND DEATH 3 Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1-28-61 to 4-13-63 and last saw him alive on 4-11-63 Death occurred at 5:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F.G. Barnett, M.D.		22b. ADDRESS Paris, Mo.	
22c. DATE SIGNED 4/13/1963			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APRIL 16, 1963	23c. NAME OF CEMETERY OR CREMATORY WALNUT GROVE CEM.	
24. FUNERAL DIRECTOR ADDRESS E.H. AGNEW - PARIS, MO		25. DATE RECD. BY LOCAL REG. 4-13-63	
26. REGISTRAR'S SIGNATURE F.G. Barnett, M.D.			

APR 22 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. H. Ognew

Licensed Embalmer No. 4000

P. O. Address Paris, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.